2005 Medical Plan Options	Commonwealth Preferred		Commonwealth Essential		Commonwealth Premium	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Annual Deductible	Single: $400 Family: $800	Single: $800 Family: $1,600	Single: $750 Family: $1,500	Single: $1,500 Family: $3,000	Single: $250 Family: $500	Single: $500 Family: $1,000
Maximum out-of-pocket for Covered Expenses (including deductible) *Co-payments and co-insurance for prescription drugs and co-payments for emergency room visits do not apply to the out-of-pocket limits. All others apply.*	Single: $2,000 Family: $4,000	Single: $4,000 Family: $8,000	Single: $3,500 Family: $7,000	Single: $7,000 Family: $14,000	Single: $1,000 Family: $2,000	Single: $2,000 Family: $4,000
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
In Hospital Care *Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and substance abuse.*	20%*	40%*	25%*	50%*	10%*	30%*
Outpatient Services.						
▪ *Physician or Mental Health Provider – Office visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, injections, lab fees, x-rays, and mental health/substance abuse services*	20%*	40%*	25%*	50%*	10%*	30%*
▪ *Routine physicals, and certain early detection tests. Well childcare and immunizations. Age and periodicity limits apply.*	100% up to a $200 maximum per person per year plus 100% of eligible immunizations		100% up to a $200 maximum per person per year plus 100% of eligible immunizations		100% up to a $200 maximum per person per year plus 100% of eligible immunizations	
▪ *Diagnostic Testing - laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury.*	20%*	40%*	25%*	50%*	10%*	30%*
▪ *Ambulatory Hospital and Outpatient Surgery – outpatient surgery services, outpatient surgery physician fees, radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).*	20%*	40%*	25%*	50%*	10%*	30%*
Emergency Services						
▪ *Hospital Emergency Room – $50 co-pay per visit is waived if admitted (hospital coinsurance still applies)*	$50 copay then 20%*	$50 copay then 40%*	$50 copay then 25%*	$50 copay then 50%*	$50 copay then 10%*	$50 copay then 30%*
▪ *Emergency Room Physician*	20%*	40%*	25%*	50%*	10%*	30%*
▪ *Urgent Care Center (not hospital emergency room)*	20%*	40%*	25%*	50%*	10%*	30%*
▪ *Ambulance*	20%*	40%*	25%*	50%*	10%*	30%*
Maternity Care - *Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval.*	20%*	40%*	25%*	50%*	10%*	30%*

2005 Medical Plan Options	Commonwealth Preferred				Commonwealth Essential				Commonwealth Premium			
	In-Network		Out-of-Network		In-Network		Out-of-Network		In-Network		Out-of-Network	
Prescription Drugs Retail – Co-insurance *The member pays the co-insurance percentage shown above, subject to the minimum and maximum amounts shown below for each type of prescription. Co-insurance applies to each 1-month (30-day) supply. If the total cost of the prescription is less than the minimum payment, the member will pay the lesser amount. Preauthorization may be required for certain drugs. Drugs are not covered for non-covered services.*	20% Min	Max	40% Min	Max	25% Min	Max	50% Min	Max	10% Min	Max	30% Min	Max
▪ *Generic*	$10	$25	$10	None	$10	$25	$10	None	$10	$25	$10	None
▪ *Preferred Brand*	$20	$50	$20	None	$20	$50	$20	None	$20	$50	$20	None
▪ *Non Preferred Brand*	$35	$100	$35	None	$35	$100	$35	None	$35	$100	$35	None
Prescription Drugs Mail Order – Co-insurance *The member pays the co-insurance percentage shown above, subject to the minimum and maximum amounts shown below for each type of prescription. Co-insurance applies to each 3-month (90-day) supply of maintenance drugs only. If the total cost of the prescription is less than the minimum payment, the member will pay the lesser amount. Preauthorization may be required for certain drugs. Drugs are not covered for non-covered services.*	20% Min	Max	Not applicable		25% Min	Max	Not applicable		10% Min	Max	Not applicable	
▪ *Generic*	$20	$50	Not applicable		$20	$50	Not applicable		$20	$50	Not applicable	
▪ *Preferred Brand*	$40	$100	Not applicable		$40	$100	Not applicable		$40	$100	Not applicable	
▪ *Non Preferred Brand*	$70	$200	Not applicable		$70	$200	Not applicable		$70	$200	Not applicable	
Other Services												
▪ *Audiometric – Only covered in conjunction with a disease, illness or injury.*	20%*		40%*		25%*		50%*		10%*		30%*	
▪ *Chiropractor – Limit of 26 visits per year with no more than one visit per day.*	20%*		40%*		25%*		50%*		10%*		30%*	
▪ *Durable Medical Equipment (DME) and Prosthetic Devices*	20%*		40%*		25%*		50%*		10%*		30%*	
▪ *Hearing Aids (Under 18 years of age. One per ear every three years, $1,400 maximum per ear.)*	20%*		40%*		25%*		50%*		10%*		30%*	
▪ *Autism Services* ➢ *Rehabilitative and Therapeutic care* ➢ *Respite Care - $500 maximum monthly benefit for children 2 through 21 years of age*	20%* 20%*		40%* 40%*		25%* 25%*		50%* 50%*		10%* 10%*		30%* 30%*	
▪ *Hospice – Certain limits apply. Must be precertified by Plan.*	Covered same as Medicare Benefit				Covered same as Medicare Benefit				Covered same as Medicare Benefit			
▪ *Home Health – Limit 60 visits per year.*	20%*		40%*		25%*		50%*		10%*		30%*	
▪ *Physical Therapy – Limit 30 visits per year.*	20%*		40%*		25%*		50%*		10%*		30%*	
▪ *Occupational Therapy – Limit 30 visits per year.*	20%*		40%*		25%*		50%*		10%*		30%*	
▪ *Cardiac Rehabilitation Therapy – Limit 30 visits per year.*	20%*		40%*		25%*		50%*		10%*		30%*	
▪ *Speech Therapy – Limit 30 visits per year.*	20%*		40%*		25%*		50%*		10%*		30%*	
▪ *Skilled Nursing Facility – Limit 30 days per year*	20%*		40%*		25%*		50%*		10%*		30%*	

* Deductible applies. Once deductible is met, the member pays the co-insurance percentage that is indicated for that service

Notes: Visit limits and/or dollar limits are applied on a combined basis when both in-network and out-of-network benefits are offered.
Prior approval may be required for some services.
Hospital emergency room services, including physician services in a hospital emergency room, and ambulance services are paid at the in-network benefit level even when services are received from an out-of-network provider in true emergency situations as determined by the Carrier.